

Northwest Regional Heart and Vascular

10000 SE Main Street

Suite 60

Portland, OR 97216

(p) 503-257-0959

(f) 503-256-7757

**Request for Cardiac Monitor**

**This form is for cardiac monitor ONLY**. This **does not** include a consult to see a Cardiologist, submit separate referral if required. Please send completed form along with copy of the patient’s **demographics, authorization and clinic note** by fax to (503)-256-7757.

For additional Cardiology testing, please contact Hospital Cardiology Department at 503-251-6123. Any questions regarding monitors or cardiology consults, contact us at Northwest Regional Heart and Vascular

(503)-257-0959.

**Demographics**

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Date of Referral Patient Name Date of Birth Patient phone

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Referring MD Name Office address Office phone Office fax

MD signature: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- | --- |
|  |  |  |
| ICD-10 & Diagnosis |  | Insurance Provider/ID # |
|  YES or NO  |  |  |
| Preauthorization required? |  | Authorization # |

**Indication**

**CPT’s for insurance authorization:**

 **3-7 days are 93242, 93243, 93244 8-14 days are 93246, 93247, 93248**

**Cardiac Testing:**

[ ]  Zio monitor – (3-14 days) Long term monitoring with ability for manual triggered events.

 Specify # of days\_\_\_\_\_\_\_\_\_\_\_\_

**Please feel free to contact us with any questions or concerns. Thank you.**